



Prurigo pigmentosa: Case series and differentiation from confluent and reticulated papillomatosis

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Key words: confluent and reticulate papillomatosis; prurigo pigmentosa; pruritus.

INTRODUCTION

Prurigo pigmentosa (PP) is an uncommon, acquired inflammatory disorder with a predilection for young adults of Asian descent.¹ This condition is manifested by highly pruritic, reticulated, and erythematous papules that resolve with hyperpigmentation.² Multiple cases of PP have been reported since its initial description in 1971 by Nagashima et al³; however, this dermatosis is still underdiagnosed or misdiagnosed.³⁻⁶ The most significant challenge limiting the identification of PP is successful distinction from confluent and reticulated papillomatosis (CARP). Herein, 2 patients with PP are described, with a focus on differentiating features from CARP.

CASE SERIES

Patient 1

A 30-year-old Chinese man presented with reticulated erythematous and hyperpigmented papules on his back and shoulders (Fig 1, A and B). The eruption was present for 2 weeks and was associated with severe pruritus. Histopathologic evaluation of a punch biopsy found a subacute spongiotic dermatitis with dyskeratosis (Fig 2, A and B). After treatment with minocycline, 100 mg, and halobetasol 0.05% ointment, both twice daily for 6 weeks, the erythema and pruritus resolved, but hyperpigmentation was persistent (Fig 1, C).

Patient 2

A 31-year-old Indian man presented with a pruritic reticulated eruption on the back, chest, and chin.

Abbreviations used:

CARP: confluent and reticulated papillomatosis
 PP: prurigo pigmentosa

At the time of presentation, the eruption was present for 3 months and was composed largely of hyperpigmented papules (Fig 3, A and B). Prior treatment with topical hydrocortisone was unsuccessful. Similar to the histopathologic findings observed in patient 1, a punch biopsy found a subacute spongiotic dermatitis with necrotic keratinocytes and pigment incontinence. After treatment with minocycline, 100 mg, and halobetasol 0.05% ointment, both twice daily for 4 weeks, the papular pruritic lesions resolved, but hyperpigmentation was persistent.

DISCUSSION

PP presents with a reticulated morphology, with erythema and pruritus dominating the acute stage and hyperpigmentation predominant in the chronic stage; coexistence of stages is frequent.^{5,7} CARP is also manifested by hyperpigmented papules with a netlike appearance and a predilection for the trunk and proximal extremities.⁸ PP and CARP have overlapping clinical morphology, and PP may be clinically diagnosed as CARP given the rarity of the former compared with the latter diagnosis.⁷ Recently, a case was reported with features of both PP and CARP, suggesting that these conditions may represent a spectrum rather than separate entities.⁷

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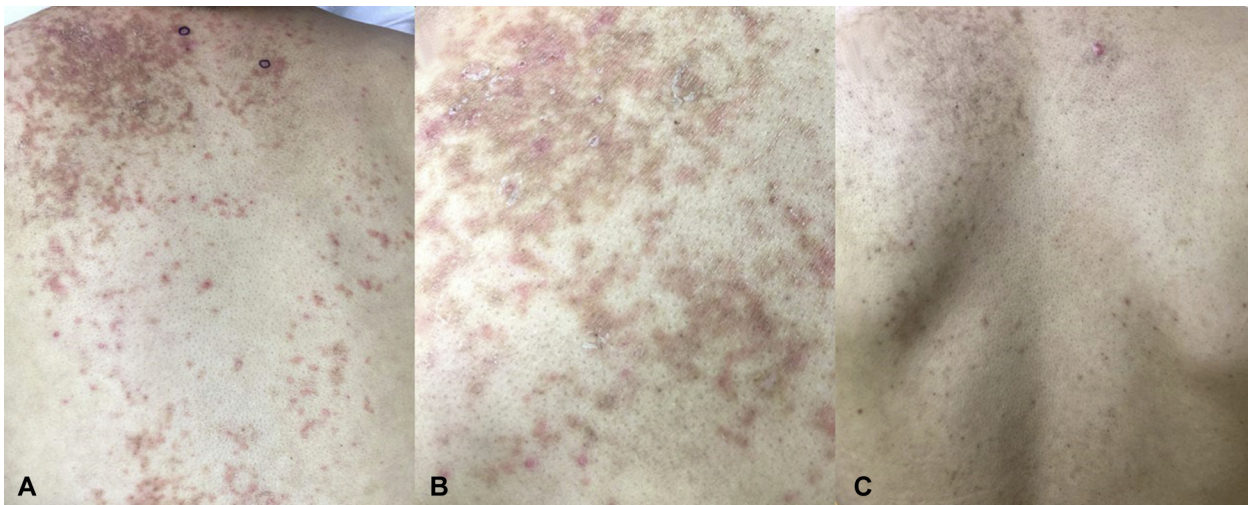


Fig 1. **A**, Reticulated erythematous and hyperpigmented papules on the back of an Asian man. **B**, Fine scale is evident and most of the papules are erythematous in the acute stage; the eruption was present for 3 weeks. **C**, After treatment with minocycline and halobetasol for 6 weeks, the erythematous papules resolved but reticulate hyperpigmentation was persistent.

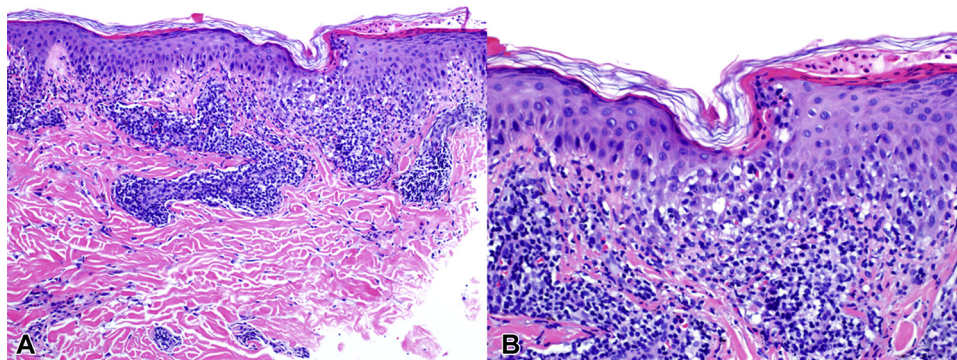


Fig 2. **A**, Subacute spongiotic dermatitis with a superficial perivascular lymphohistiocytic infiltrate. **B**, Dyskeratosis, lymphocyte exocytosis, and Langerhans cell microabscesses are evident. (**A** and **B**, Hematoxylin-eosin stain; original magnifications: **A**, $\times 100$; **B**, $\times 200$.)

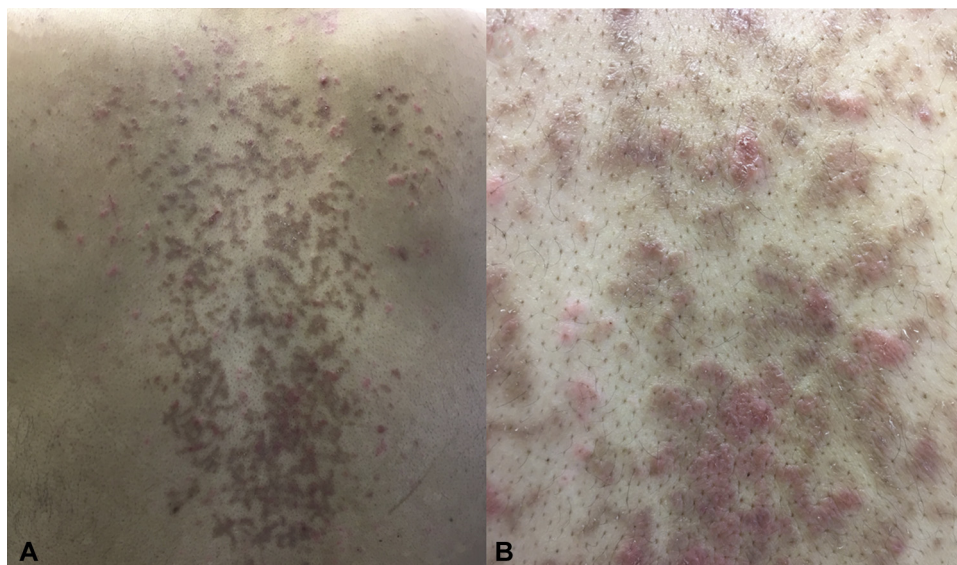


Fig 3. **A**, Reticulated erythematous and hyperpigmented papules and plaques with confluence on the back of an Indian man. **B**, The majority of the papules are hyperpigmented at this stage, several months after onset.

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